

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

7069

**1. PLACE OF DEATH**

County..... Registration District No. 7E  
 Township..... Primary Registration District No. 100E  
 City ST. LOUIS (No. 5559, MAPLE AVE St. \_\_\_\_\_ Ward) \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 1937

**2. FULL NAME** ALMA HOFFINGER

(a) Residence. No. 5559 MAPLE AVE St. 5 Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) WIDOWED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF CARL F. L. HOFFINGER

6. DATE OF BIRTH (MONTH, DAY AND YEAR) OCTOBER 13 1867

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>62</u>	<u>4</u>	<u>10</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. AT HOME  
 (b) General nature of industry, business, or establishment in which employed (or employer).  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) BELLEVILLE  
 (STATE OR COUNTRY) ILLINOIS

10. NAME OF FATHER UNKNOWN

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) UNKNOWN

12. MAIDEN NAME OF MOTHER CATHERINE STUEBINGER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) UNKNOWN

14. INFORMANT Agnes Ruth Hoffinger  
 (Address) 6559 Maple Ave

15. FILED \_\_\_\_\_ 19 \_\_\_\_\_  
W. C. Hawley  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 23 1930

17. No Physician in attendance  
 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ 5 A. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Lobar Pneumonia  
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 10/10  
 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) W. C. Hawley M. D.

74 1930 (Address) 1010

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Valhalla Crematory DATE OF BURIAL Feb 25 1930

20. UNDERTAKER C. R. Dupton ADDRESS 4449 Olive St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

